

**Healthcare Debt in the United States: An Analysis of Consumer Healthcare Debt and Its
Impact on Healthcare Systems**

by

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Abstract

Healthcare debt in the United States (US) has become an economic and public health issue that continues to place a financial strain on individuals and healthcare systems. More policies could be enacted to assist individuals bearing the financial burden of healthcare debt. There are a number of ways to receive assistance in paying for healthcare debt, but none of the current solutions are consistent or sustainable in the long-term. Policy solutions must be enacted to assist individuals and families bearing this burden currently and in the future.

The policies being proposed in this paper include both a federal and employer-based healthcare debt solution. The federal policy would include creating a new Community Development Financial Institution (CDFI) Fund program that would provide low-interest lending options to patients post care. The employer-based policy would create a healthcare repayment loan program for employees who are struggling with healthcare debt. Each of these alternative options include assistance to the individual and the hospital, while holding the insurance companies and employers accountable.

The potential healthcare debt policies explored in this paper also have public health relevance. The issues each policy attempts to address are tied to both an individual's mental health

and their access to care. By providing individuals with financial options they feel more in control and not as overburdened by bankruptcy as their only option. With additional options for healthcare debt payment, individuals do not feel as overburdened about accessing healthcare for preventative care. In addressing these public health issues, fewer individuals would have to rely on the emergency department for their care and more on their general practitioner.

The proposed policies for healthcare debt take both the patient and healthcare organization into consideration, with the overall goal of cutting out the collections agencies and payday lenders. By providing a sustainable, financial assistance program that will continue to benefit additional patients in the future, fewer individuals will file for bankruptcy and fewer hospitals will have to write-off bad debt. These policies not only have the potential to benefit individuals and hospitals, but also the US economy.

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Preface

I would like to acknowledge a number of people that have helped make this essay possible and have supported me in my education and research at the University of Pittsburgh. First, I would like to thank Dr. Kevin Broom for taking on my essay topic. Thank you for letting me take an out of the box approach and for providing me with your support throughout the process.

Some of the research for this paper would not have been possible without the University of Pittsburgh School of Social Work. The School of Social Work was instrumental to my local Pittsburgh research on medical debt through the use of the *Pittsburgh Wage Study* Wave 2 survey data. I would also like to thank Dr. Jeffery Shook and Dr. Sara Goodkind for agreeing to share pertinent survey data with me that they have been collecting and agreeing to be readers for my essay.

I would like to thank my husband, Andrew Pack, for his unwavering support in accomplishing my dream of attaining my master's in health administration. He has been by my side throughout the two years encouraging me to reach for the stars. In addition, I would like to thank both of our families for their love and support as I accomplish my goals.

1.0 Introduction and Problem Statement

Between 2015 and 2017, 137.1 million adults between the ages of 18 and 64 in the United States (US) reported financial hardship tied to medical debt (Yabroff et al., 2019, p. 1494). This is approximately 41.9 percent of US citizens, based on the total estimated population by the 2018 American Community Survey (2020). Even more staggering is the 58.5 percent of debtors in the US that filed bankruptcy between 2013 and 2016 who indicated it was attributed to medical expenses (Himmelstein et al., 2019, p. 432).

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 was intended to provide insurance coverage to more US citizens and banned insurance companies from precluding individuals with preexisting conditions from receiving access to health insurance (Himmelstein et al., 2019, p. 431). The ACA has decreased the number of uninsured individuals, while the gross domestic product (GDP) of healthcare has increased from 13.3% in 1998 to 17.9% in 2017 (Shinkman, 2020).

The total bad debt from US community hospitals where the patient nor the insurance company provided payment, uncompensated care, totaled \$38.4 billion for 2016 and 2017, respectively (Wiik, 2019). According to the American Hospital Association (AHA), uncompensated care has been on the rise since 1990 (Wiik, 2019). After the ACA was adopted, the amount of uncompensated care dropped for the first time in 2015, but rose again in 2016 (AHA, 2020). In 2018, the total amount of uncompensated care reported by 5,198 community hospitals was \$41.3 billion (AHA, 2020).

To better understand the issue on a smaller scale, the state of Pennsylvania will be looked at in closer detail. The Pennsylvania Health Care Cost Containment Council (PHC4) reported a

two percent decrease in uncompensated care by acute care hospitals in the state from 2017 to 2018 (Martin, 2019). The total uncompensated care in 2018 was \$750 million, which is the most recent data available from PHC4 (Martin, 2019). With a total population of about 12.8 million, this calculates to about \$59 per person in the Commonwealth of Pennsylvania (2020). While this may not seem like much per person, it adds up when the total uncompensated care is at the same rate every year across all fifty states in the US.

For the purposes of this paper, healthcare debt encompasses individuals, both insured and uninsured, who receive a bill from a healthcare provider and are unable to pay the balance in full within the allotted billing period. The focus of this paper will be placed on the individual experiencing healthcare debt and potential policies that would be beneficial to them in paying off their healthcare debt.

There is currently not a state or federal policy focused primarily on healthcare debt as defined within the context of this paper. California and Colorado have proposed policies to lower healthcare costs, yet have not been able to enact these changes because of opposition by hospital groups (Cohrs, 2020). At the federal level, balanced “surprise” billing is currently being debated (Cohrs, 2020). Balanced billing or “surprise billing” is when an out-of-network provider charges a consumer for the difference in what their insurance company will cover (Healthcare.gov). The current primary options for individual healthcare debt include the following models: vendor, banking, in-house, crowdsourcing, Health Savings Accounts (HSA), Flexible Spending Account (FSA), or Health Reimbursement Arrangements (HRA).

The vendor model is where a health care system partners with a financial institution to provide lending options to their patients. ClearBalance Healthcare and Patientco are examples of such vendors. ClearBalance Healthcare provides patients with consumer-friendly financing

options to assist individuals with paying off their out-of-pocket healthcare expenses (ClearBalance, 2020). Patientco is another example of a vendor model that provides even more financing options to patients with a “consumer-friendly financial experience” (Patientco, 2020). Both of these organizations are peer reviewed by the Healthcare Financial Management Association (HFMA). Not all health systems partner with these financial institutions, thus making each hospital different in how they handle patient out-of-pocket payments.

Some hospitals offer what could be considered a banking model, which includes financing options offered in partnership with a bank. Some hospitals have been able to work out no cost or interest for these agreements. An example of this is SSM Healthcare, which is located in four states in the mid-west (Murphy, 2016). They have partnered with Commerce Bank that offers three payment options based on the patient’s account balance (SSM Healthcare, 2020).

Another avenue some hospital’s leaders have taken is an in-house repayment model. This model provides patients with an interest-free, twelve-month payment period to pay back their medical expenses incurred. A hospital that has done this is St. Luke’s Health System in Boise, Idaho (Murphy, 2016). They first implemented this in October 2014 to assist Idaho residents whose Medicaid program had not been extended through the ACA. The financing terms include zero-percent interest for up to twelve months, five percent interest for twelve to twenty-four months and accounts that have not been paid off within thirty-six months are charged 8 percent interest (Murphy, 2016).

Crowdsourcing is a model that has really been making headlines in the twenty-first century and more popularly known as crowdfunding. There are a number of platforms online that provide individuals with a way to raise funds from other individuals without the expectation of being paid in return. GoFundMe is one of the platforms a number of patients and families turn to when they

are looking to payoff health care debt. GoFundMe provides an online platform for individuals, family, or friends to setup a fundraising campaign for anyone to donate online with the click of a button (GoFundMe, 2020). According to The New Yorker, GoFundMe reported that a third of funds raised through their platform in 2017 were for medical expenses (Heller, 2019). This is a shocking amount of money raised directly for medical expenses with the individuals giving knowing they will not receive anything in return for their donation.

There have been a few government-supported healthcare benefits that have been created for employers, employees and small businesses including Health Savings Accounts (HSA), Flexible Spending Accounts (FSA) and Health Reimbursement Arrangements or Accounts (HRA). The goal of each of these programs is to allow individuals to take money out of their paycheck on a pre-tax basis for healthcare expenses that premiums do not cover. HSAs are for individuals with “High Deductible Health Plan (HDHP)” and can be used to cover “deductibles, copayments, coinsurance, and some other expenses” (Healthcare.gov, 2020). FSAs are for employees whose employer provides health insurance, but allows the employee to take up to \$2,650 out of the individual’s paycheck each year (Healthcare.gov, 2020). The amount the employee requests can be spent on medical and dental expenses within one year, excluding insurance premiums (Healthcare.gov, 2020). An HRA is an employer-funded plan that provides employees with an allotted amount of money each year to use to pay for health-related expenses (Healthcare.gov, 2020).

As outlined above, there have been a number of private and public healthcare debt payment options implemented to assist individuals and their families in paying for medical debt. However, there are still measures the government could take to assist individuals across the US in providing medical debt relief options. The problem being addressed in this paper is that healthcare debt has

increasingly become an economic and public health issue that affects almost half of the US population. Policies must be enacted to assist individuals and families bearing this burden and to improve accounts receivable balances for healthcare institutions post insurance reimbursement.

2.0 Evidence

Healthcare debt can look different on a national, state and local level because every healthcare delivery system has different policies for paying healthcare bills. From recent studies, we can find relevant data to support the growing healthcare debt problem within the US. In 2018, a survey conducted by the Federal Reserve Board of Governors indicated that 12 percent of US adults would not be able to pay an unexpected bill of \$400, while an additional 27 percent would have to borrow the money or liquidate assets to cover the cost (2019). In addition, at least four million US citizens borrowed a total of \$88 billion to pay for healthcare in 2018 (Gallup, 2019). As someone who has never experienced healthcare debt or is well insured, it would be unimaginable to think that individuals have borrowed billions of dollars in one year to cover their healthcare expenses, even with 11 percent of those being covered by health insurance (Gallup, 2019). Unfortunately, this is an everyday reality for many Americans.

In the state of Pennsylvania approximately 2.1 million adults have unpaid medical bills with a median in collections of \$512 (Stebbins, 2020). Unpaid medical bills make up about 21.1 percent of the adult population of Pennsylvania (Stebbins, 2020). The state of Pennsylvania is the twentieth lowest state in the country affected by unpaid medical bills (Stebbins, 2020). The reported uninsured rate in Pennsylvania is 5.5 percent, which is the eleventh lowest uninsured rate in the US (Stebbins, 2020).

In looking at healthcare debt on a more local level, the University of Pittsburgh School of Social Work has been conducting surveys in conjunction with a local hospital to study low-wage workers and to better understand the economic challenges they face (Shook, et al., 2019). The School of Social Work is conducting a series of three surveys called the *Pittsburgh Wage Study*,

which has completed two of three surveys since May of 2017. The total number of respondents during the second wave of surveys conducted makes up 25 percent of the hospital's service, clerical, and technical employees. The group surveyed did not include doctors, nurses, or administrators.

The data used for this paper came from the second wave survey conducted between August 2018 through January 2019. The data from this survey that was relevant to healthcare debt was requested from the University of Pittsburgh's Social Work department. The data was then evaluated as it related to financial indicators, health insurance and quality of life.

Fifty-eight percent of respondents indicated they were living paycheck to paycheck (Shook et al., 2019). To get a better idea of savings among those interviewed, it was asked how strongly they agree or disagree that "an emergency would financially ruin me" (Shook et al., 2019). The majority of the respondents agreed or strongly agreed, at 37 and 43 percent, respectively (Shook et al., 2019). This indicates that 80 percent of the service, technical, and clerical employees of the hospital do not have enough saved for an emergency financial situation. Of these hospital workers, 47 percent of respondents indicated they "owed money for medical treatment" (Shook et al., 2019). Seventy-one percent indicated they participated in work-related health insurance benefits (Shook et al., 2019).

Not only has there been more studies and research around the number of individuals affected at a national, state and local level, a number of organizations have started reporting on these issues. Three of the organizations that have been working to bring a face and name to the health care debt issue include CBS News, ClearHealthCosts and *An Arm and a Leg* podcast. CBS News in conjunction with ClearHealthCosts have been soliciting individuals' stories for what they call "Medical Price Roulette" (2020). The first of these articles dates back to September of 2019

(CBS News, 2020). The podcast *An Arm and a Leg*, created by Dan Weissmann, started back in November of 2018 and has recently completed season three. The podcast seeks to provide real-time examples and lessons the author has learned from interviewing experts in the field to everyday people who have learned how to mitigate their medical debt creatively (An Arm and a Leg, 2020).

Hospitals suing patients for balances not paid in full has become more common in the last couple of years. According to The New York Times, Carlsbad Medical Center in New Mexico had filed about 3,000 lawsuits between 2015 and 2019 and Methodist Le Bonheur Healthcare in Memphis, TN has “filed 8,300 lawsuits from 2014 through 2018” (Beil, 2019). According to ProPublica and MLK50, some of the lawsuits at Methodist Le Bonheur were against their own employees (Beil, 2019). This aligns with the findings from the *Pittsburgh Wage Study* discussed earlier of 47 percent of healthcare workers finding themselves in debt from medical bills (Shook et al., 2019). However, which health care facility they were indebted to was not reported in the survey.

From 2015 to 2018, despite the passage of the ACA, bad debt for hospitals in the US “increased by \$617 million” to about \$56.6 billion (Hawryluk, 2020). The large number of patients filing bankruptcy could be attributed to the US Generally Accepted Accounting Principles (GAAP) accounting standard, “Revenue from Contracts with Customers, or Topic 606,” that took effect after December 15, 2017 (Advisory Board, 2018 & Bannow, 2018). Topic 606 only permits hospitals to write off bad debt “in instances when an adverse event, such as bankruptcy or loss of employment, prevents a patient from paying what the hospital, based on historical experience, expected to receive” (Advisory Board, 2018).

It can be inferred that those who are insured and have been sued for medical debt are individuals who are healthy and opt for the lower health insurance premiums. However, if they do

face a medical emergency during the year, they will face a higher deductible. These individuals would be considered underinsured if their deductible makes up five percent of their household income (Collins et al., 2019).

The Patient Protection Affordable Care Act (ACA) was designed to assist in covering those who did not have access to health insurance, also known as the uninsured. The rate of uninsured individuals in the US has been cut in half since 2010 with 27.9 million Americans being uninsured in 2018 (Tolbert, et al., 2019). Those uninsured account for about 10.4 percent of the US population (Tolbert, et al., 2019).

Because there are so many who are still uninsured and underinsured, there has been a push for “Medicare for All” the past couple of years in political debates, but it has not received enough support in Congress to be enacted. The “Medicare for All” policy comes in many shapes and sizes, as it has not formally been passed as legislation. Many politicians currently have different models as to how this policy should come together. The overall goal of “Medicare for All” is to provide insurance for everyone regardless of if they meet the Medicaid requirements or not.

While providing health insurance for all US citizens should be a priority, more focus could be placed on those who are currently in healthcare debt from past health emergencies to decrease healthcare debt in the US. Loans for healthcare debt are available, but they tend to be unsecured with fixed interest rates, a payoff period of two or three years and only for individuals with good credit (Fay, 2019). It is clear that healthcare debt should no longer be placed on the policy backburner and more attention needs to be brought to the forefront of this topic by our legislatures to provide much needed relief to a good portion of the US population.

3.0 Current and Future Policies

The future federal policy this research can contribute to would be ideal for all US citizens and provide a safety net for individuals. Providing individuals with the financial resources they need to get back on their feet would have a higher return on investment than suing patients whose lawyers make money off the backs of the same individuals that cannot pay back their healthcare debt (CBS News, 2020). Policies that have been put in place focus on regulating insurance companies in addition to current debates in Congress on policies that would mitigate surprise billing.

Health plans are regulated by each state's department of insurance and the National Association of Insurance Commissioners (NAIC) (Hodin & Turnbull, 2019). All of these regulators have been put in place to hold insurance companies accountable for their capital reserves, admitted assets and to evaluate their Risk Based Capital ratio to ensure they are able to cover their members (Hodin & Turnbull, 2019).

The only legislation in place for surprise billing is on the state level in twenty-eight states across the US (Hoadley et al., 2020). These states have put consumer protections in place; however, states are not able to protect against employer self-funded plans on account of the federal Employee Retirement Income Security Act (ERISA) (Hoadley et al., 2020). In addition, air ambulance services cannot be protected against at the state level; therefore, there are still measures that need to be made to protect consumers from surprise billing at the federal level (Hoadley et al., 2020).

Surprise billing has been a hot topic in Congress in early 2020. There have been three bills proposed with two being approved by separate House Committees in mid-February (Hoadley et

al., 2020). Both bills would ensure patients who receive out of network treatment only receive bills at in-network rates by their insurance (Hoadley et al., 2020). The difference in the two bills is how the insurance companies will reimburse the out-of-network provider (Hoadley et al., 2020). However, on account of the coronavirus disease 2019 (COVID-19) pandemic Congress' attention was forced to focus on more pressing policy matters.

The President and Congress have now enacted three bills to assist the economy and individuals who have been furloughed or laid off on account of stay-at-home orders issued by a number of Governors across the country to reduce the spread of the virus. Congress is now anticipating the need for a fourth bill that would be considered a “coronavirus-response package” (Lee & Ruoff, 2020). The House Energy and Commerce Committee's ranking member, Greg Walden (R-Ore.), believes this is the opportunity to include surprise billing in this legislation (Lee and Ruoff, 2020). This bill will help reduce future consumer bills, but the healthcare debt many patients have will continue to follow them beyond this legislation; therefore, a more focused medical debt policy needs to be considered.

3.1 Proposed Federal Policy

To address the current healthcare debt issue in the US, it is proposed that a federal policy be enacted to create a healthcare loan program for individuals similar to that of the Community

Development Financial Institution (CDFI) Fund's¹ CDFI Program (2020, p. 18). Government funding would be allocated to certified CDFIs that apply for CDFI funding to lend to individuals who are unable to pay off their healthcare bills upon receiving their bill in the mail post-care. In addition to receiving a loan from a CDFI, individuals would be provided with financial counseling as part of the loan's technical assistance component.

The loan funds for CDFIs come through varying investment pools, as they are required to match the "Financial Assistance awards" they receive from the United States Department of the Treasury dollar-for-dollar (CDFI Fund, 2020, p. 19). The federal government would provide half of the funds for the loan program through the CDFI Fund, as they currently do for existing CDFI programs. The other half of the loan funds would come from investment capital to match the federal dollars.

To better understand how the CDFI program would work for the proposed healthcare debt CDFI program, please refer to Figure 1 below (Emeka, n.d.). Banks and private investors work with CDFIs to match the federal funds received from the US Treasury to then be lent out to borrowers. The borrowers then pay the loan back to the CDFI, as they would a conventional bank loan. As loans are paid in full, banks and private investors receive a percentage of their investment from the CDFI with the option to lend the earnings back to the CDFI or keep the returned earnings. When the banks and private investors return the earnings, this creates a revolving loan pool for the

¹ The CDFI Fund was enacted by Congress in 1994 "to provide federal support for CDFIs serving low-income communities through equity investments, capital grants, loans and technical assistance support" (Balboni & Travers, 2017, p. 5). There are a number of programs available through the CDFI Fund for "underserved low-income communities," with individuals only allowed funds through the CDFI Program Disability Funds-Financial Assistance (2020, p. 7).

CDFI. To be eligible for the CDFI programs, the organization must be a certified CDFI (CDFI Fund, 2020).

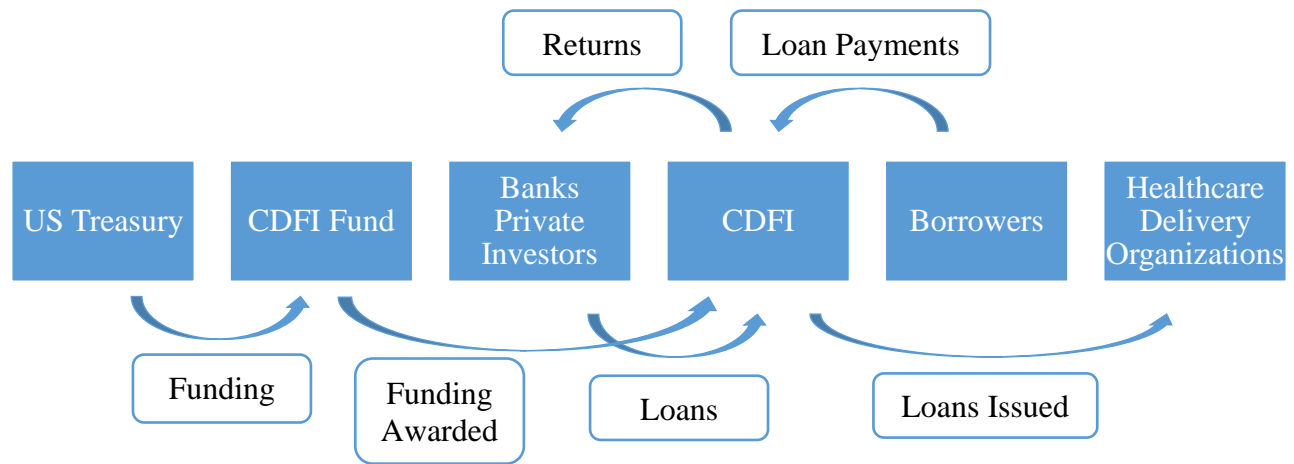


Figure 1 CDFI Operational Model

Certified CDFIs can be structured differently, as there are four different types as outlined in Figure 2 below. Community development banks are for-profit depository institutions, while community development credit unions are not-for-profit financial cooperatives (Opportunity Finance Network [OFN], 2020). Community development loan funds are typically not-for-profit organizations that “provide financing and development services to businesses, organizations, and individuals in low-income communities” (OFN, 2020). The fourth type are community development venture capital funds that provide assistance to “small and medium-sized businesses” in economically distressed communities (OFN, 2020).

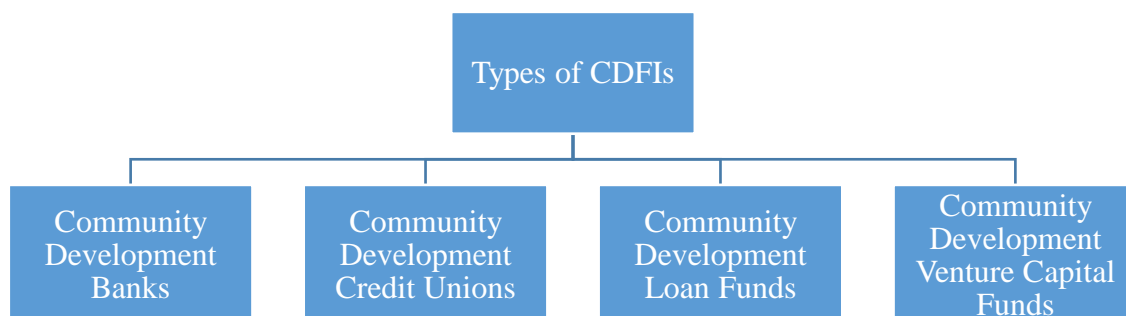


Figure 2 Types of CDFIs

The government funding would come through a certified CDFI that would then lend the money to an individual borrower with healthcare debt, upon loan approval. The proposed policy would be supported through a pool of funds that would be designated for this fund from private investors, such as, insurance companies, individuals, and private foundations that would receive a return on their investment as the loans were paid back or could be reinvested in the loan pool for additional future healthcare loans, as demonstrated in Figure 1 above (CDFI Coalition, 2020).

Three organizations, Community Catalyst, Center for Consumer Engagement in Health Innovation and the Kresge Foundation, came together to develop an issue brief on how health plans could make investments in housing and community development through CDFI investments (Hodin & Turnbull, 2019). This issue brief would support the policy recommendation being made, as there is excess revenue made by health plans that could be invested in such a funding mechanism (Hodin & Turnbull, 2019). By having insurance companies provide match for healthcare debt loans, this would provide additional support to the CDFI Program being proposed and allow health plans to invest their assets in a program that would benefit not only their members, but those who are unable to be insured.

As mentioned in the introduction, Crowdfunding is a popular means in which to pay-off healthcare debt. It is also a way for people, who would not otherwise know each other, to donate to someone in need of financial relief from healthcare debt (Heller, 2019). From looking at how much money can be raised for individual situations it would seem an opportunity to invest in a revolving loan pool around individual healthcare debt could support a large percentage of the dollar-for-dollar match required of the CDFI program.

Private foundations award grant funding to many CDFIs to deliver technical assistance in addition to loan funds to small businesses and communities. Much of this funding is applied for

through CDFI institutions to support technical assistance and capacity building among communities and small businesses through programming. These programs support the work of the CDFI post-loan to ensure the community or small business has the ability to pay back the loan within the terms of the loan.

The proposed solution would allow hospitals to be paid directly by the lending institution when the loan is made. This would relieve the hospital from collecting on the existing bill and the legal expenses of suing the individual for not paying off their accounts; therefore, creating a win-win solution for healthcare institutions. The initial funding from the US Treasury would be small and would focus on individuals with healthcare debt greater than \$300 and less than \$15,000. By starting small, a proof of concept could be established for additional CDFIs to easily adopt and begin to build a loan pool for this specific program.

The CDFIs that are awarded funding for this program will be expected to provide technical assistance to the individuals who receive the loans. This technical assistance will include financial counseling with the individuals that receive a loan for healthcare debt to make sure they are on track to make their payments each month. This form of technical assistance is also considered capacity building for low-income individuals who otherwise would not qualify for a bank loan to cover their expenses. It is understandable that not everyone will have the time or willingness to participate. The technical assistance would only require that one session be conducted, with two additional attempts to contact the individual for additional assistance after the first consultation.

The policy would also need to indicate that all healthcare institutions that receive Medicare or Medicaid funding must send a list of approved CDFIs for healthcare debt lending to anyone listed within their accounts receivable. This will help get the awareness of the program out to the public and make them aware of the public-private healthcare loan program available for healthcare

debt purposes. It would also be required for all institutions receiving Medicare and Medicaid funding to provide information about the healthcare debt funding option when discussing financing with the patient or patient's family/guardian before being treated by a physician. Awareness of this lending option and its capabilities will be monumental in its success as a program.

The bill would need to be introduced through the US House Committee on Financial Services and/or the US Senate Committee on Banking, Housing, and Urban Affairs to make it to a House or Senate vote. The policy may be more appealing tacked onto another bill, such as one to be proposed for the economic recovery of COVID-19, should the federal budget allow.

The budget appropriations for an additional CDFI program would come from Congress in their annual fiscal year appropriations. In 2019, President Donald Trump proposed \$14 million for the CDFI Fund in 2020, which had received \$250 million for 2019. Congress in their final appropriations for fiscal year 2020 enacted \$262 million (CDFI Coalition, 2020). This was a \$12 million increase contrasted with a proposed \$236 million decrease by President Trump (CDFI Coalition, 2020). From this, it can be inferred that Congress understands the importance and relevance of the CDFI Fund.

To fund this additional healthcare debt program under the CDFI Fund, additional funds would need to be appropriated to the CDFI Fund to effectively get the healthcare debt loan program off the ground. By providing a one-to-one match, through a public-private partnership, the appropriation would begin to decrease the healthcare debt burden on individuals and healthcare institutions. The CDFI Coalition has already requested \$304 million for the CDFI Fund's fiscal year 2021 programmatic appropriations from Congress (2020). The CDFI Fund and its proponents continue to see the value of the CDFI Fund and its public-private partnerships as a strong investment in the future of small businesses and rural communities. With the passage of the

healthcare debt CDFI program, more attention could be brought to the CDFI Fund and its impact in both communities and individuals.

The federal proposal would create a larger impact on a national level to help reduce uncompensated care and reduce bankruptcy's attributed to healthcare related expenses. However, should a state, local government, or organization want to create a revolving loan pool based on this model, the window of opportunity might be more immediate than a federal level policy initiative. A local Pittsburgh example of this is the Hebrew Free Loan Association, which has been in existence since 1887 (2020). It is encouraged that the revolving loan fund model be considered if a federal policy is not enacted to mitigate healthcare debt.

3.1.1 Healthcare Debt CDFI Program Implementation Plan

The implementation plan for the healthcare debt CDFI program includes an implementation process, timeline and key metrics to track success. The program would start small and slowly grow as partnerships and funding are established among the existing certified CDFIs. The first three years will establish the proof of concept and provide time for insurance companies to begin investing in CDFIs, or become certified CDFIs themselves, that are offering the healthcare debt CDFI program.

To become a certified CDFI, an organization must apply for CDFI Certification through the CDFI Fund (2020). Applications are reviewed on a rolling basis throughout the year and awarded to those that meet a particular set of criteria as outlined by the CDFI Fund (2020). Once certified as a CDFI, the organization can then apply for technical assistance awards from the CDFI Fund (2020).

The healthcare debt CDFI program will be available for all existing certified CDFIs to apply for these financial assistance awards from the CDFI Fund upon becoming law. The timeline for applying will depend upon when the bill becomes law, for the purposes of explaining the implementation of this program, it is anticipating the bill becoming law in the fourth quarter of 2020. See Table 1 for a five-year implementation timeline for the healthcare debt CDFI program beginning in the first quarter of 2021.

Table 1 Healthcare Debt CDFI Program Five-Year Implementation Timeline

Activities*	2021				2022				2023				2024				2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Insurance companies and other organizations apply to become Certified CDFIs																				
Existing Certified CDFIs apply for the Healthcare Debt CDFI Program																				
CDFIs Raise Funds to Match their Proposed Healthcare Debt CDFI Program																				
Announcement of Awarded CDFIs																				
Newly Awarded CDFIs Begin Lending to Individuals with Healthcare Debt up to \$15,000																				
CDFIs Offer Financial Counseling to Individuals that Receive a Loan																				
CDFIs awarded the Healthcare Debt CDFI Program Lend to Individuals with Healthcare Debt																				
Healthcare Institutions that Receive Medicare or Medicaid Funding Send a List of Approved CDFIs for Healthcare Debt Lending to Anyone with Outstanding Debt																				

Table 1 Continued

[illegible]

*Assuming passage in the fourth quarter of 2020.

The current CDFI Program application window is typically between February 20th and April 30th of each year (CDFI Fund, 2020). The date of award is typically announced in the third quarter before the end of the US government's fiscal year end of September 30th. It is assumed this schedule would stay close to the same each year over the proposed five-year implementation period outlined above.

CDFIs would be expected to raise funds for federal match dollars year around to meet the match for each year's technical assistance application. The match dollars must be in place upon applying for federal funding each year to ensure funding is awarded to CDFIs. Without the proper match, the funding to the CDFI will not be approved. It was proposed in the previous section that potential match funding would come from insurance companies, individuals and private foundations.

With any federal program, accountability will be important and reviewing progress will be key. The key metrics that could be reviewed annually to track the successful implementation of the program can be found in Table 2 below.

Table 2 Key Metrics for Success of the Healthcare Debt CDFI Program

1. Number of CDFIs that apply for the Healthcare Debt CDFI Program each year
2. Number of Healthcare Debt Program loan applications per year
3. Number of awarded Healthcare Debt CDFI Program loans approved each year
4. Average amount of Healthcare Debt CDFI Program loans awarded each year
5. Number of loan recipients that participate in more than one financial counseling session each year
6. Average decrease in bankruptcy attributed to healthcare debt/medical expenses each year
7. Average decrease in uncompensated care in US hospitals each year

The first three years of implementation of the Healthcare Debt CDFI Program will be critical to its continued success. Once successful implementation has been achieved, the funding for this program can increase and larger amounts of lending dollars could be lent out to individuals who need more than \$15,000.

3.2 Proposed Employer Policy

From the survey conducted by the *Pittsburgh Wage Study*, it would appear that an employer-sponsored employee healthcare debt benefit could be beneficial to low-income employees. To focus on more of an employer policy, companies should consider additional benefits to their employees. For example, an employer could offer healthcare repayment loans to their employees who are struggling with healthcare debt as an employee benefit on an as needed basis. The employees could pay back the loan with interest pretax through their paycheck each pay period.

There are some organizations in the US that already offer loan funds to their employees for emergency purposes. Two examples of this include the Federal Employee Education & Assistance Fund (FEEA) and, for a Pennsylvania specific example, the Pennsylvania State University (Penn State) (2020). According to a study conducted by The Aspen Institute Financial Security Program and Commonwealth, organizations typically lend between \$500 to \$5,000 (2019).

A successful example of an employee loan assistance program is the FEEA's Emergency Hardship Loan Program (2020). This program is available for "full or part-time permanent federal civilian or postal employees, employed with the federal government for more than one year" who have endured financial hardship (FEEA, 2020). The loan ceiling is \$1,500 and does not require any fees or interest, as all money is raised for this fund (FEEA, 2020). FEEA is unique in that it is a not-for-profit organization that is used to benefit federal employees.

However, if you are not a federal employee or work for the postal service you do not qualify to apply for the FEEA loan program (2020). There are some employers that have been able to create similar programs for their employees across the country, but to give an example of a Pennsylvania company offering this program, Penn State was selected.

Penn State offers their employees the Employee Assistance Fund as a benefit to their employees (Penn State, 2015). This fund has been available to their employees since 2012. The funding for this comes from an endowment that was created to support its employees in need of additional financial resources in case their employees experience "a wide range of personal or family hardships" (Penn State, 2015). The amount that an employee can ask for has not been specified, but they note on their website, "[w]ith limited funds available, the level of support may be modest in relation to overall need" (Penn State, 2015). The Penn State employee assistance fund is not treated as a loan and is not expected to be paid back (2015). However, the endowment

relies on “employees and other members of the Penn State community to make further contributions” to continue to grow the endowment (2015).

From the two examples given, each have been setup independent of their organizations, one as a nonprofit organization and the other as an endowment. Not all companies have the ability to create a benefit such as this on their own, but with the proper planning, a fund can be started and slowly built upon over time to grow the employee benefit for the future.

4.0 Policy Implications/Recommendations

The federal policy presented in Section 3.1 would provide assistance to the individual and the hospital and provide lending options that would be available to all US citizens receiving care within the US. While the policy seems fairly straight forward, it is anticipated that there will be a number of policy implications to consider not limited to, but including, opposition for such a policy, how recipients would be more or less harmed and who within the public health sector would be most impacted by this policy.

Barriers to achieving federal healthcare debt CDFI loans could include opposition from particular interest groups. Some groups that might oppose this legislation include health insurance companies, “Medicare for All” proponents and collection agencies.

Health insurance companies probably would not be in favor of this policy because they would be opposed to providing match for the healthcare debt loan pool. The reason insurance companies could be an instrumental factor in getting this legislation passed is their financial influence on Congress. In 2019 alone, according to the Center for Responsive Politics, insurance companies spent \$155.2 million on Congressional lobbying activities (2020). Blue Cross/Blue Shield spent the most out of all insurance companies in 2019 at \$19.9 million (2020). The next two highest spenders in the insurance industry on lobbying activities were also health insurance companies (2020). With this kind of money and health insurance companies opposing this policy, many legislators may decide to vote against it for political reasons and campaign contributions. While this is of concern, the issue brief developed by Community Catalyst, the Center for Consumer Engagement in Health Innovation and the Kresge Foundation found that health plans have the ability to leverage capital for such a program. In essence this would give health plans a

way to engage in corporate social responsibility by providing match dollars to the public-private partnership that would provide debt relief to many of their members and the public at large.

Proponents of a single-payer insurance plan, as referred to as “Medicare for All” earlier, may be more apt to push a “Medicare for All” policy through Congress in place of a lending program for healthcare debt. With the current political and national situation of COVID-19, there could be a prime policy window to make a push for this in the next year. While this would be welcomed, the healthcare debt policy’s primarily goal would be to assist those still in debt prior to any single-payer insurance plan.

Another potential group that would be opposed to the CDFI healthcare debt program would be collection agencies. Collection agencies want the business of hospitals unable to receive payment from patients within a reasonable amount of time. The goal of this policy is to decrease the use of collection agencies and payday lenders from offering high interest loans. CDFI loans have a lower interest rate than those of collection agencies and payday lenders. In addition, hospitals would not incur expenses for the healthcare debt taken on by CDFI loans (Crouse, 2019).

The CDFI interest rates ranged from around 4% to 36% annual percentage rate (APR) based on a survey conducted by Merchant Maverick, while payday loans were “up to 400%” APR (Crouse, 2019). CDFI Funds can be more beneficial for individuals that cannot pay the healthcare debt on their own or qualify for a loan from a bank. The healthcare debt CDFI program is designed to give individuals a better option to payback their healthcare debt and for hospitals to carry less unpaid debt on their books.

Individuals who are currently experiencing healthcare debt are turning to family and friends, payday lenders, and in the worst case, bankruptcy. When individuals have to turn to family and friends to help them payoff healthcare debt, it can cause internal family issues and in turn

cause additional mental and emotional health problems. Others do not have family and friends that can offer financial support and have to turn to payday lenders instead. Payday lenders, as outlined earlier, charge a much higher APR compared to banks and CDFIs. This can cause individuals to continue in a negative financial spiral, which could end in bankruptcy if the hospital does not sue the individual first. Bankruptcy is hard for many individuals to fathom and takes many years to get back on their feet financially. By providing a more sensible option for individuals in healthcare debt, it gives people hope for a stronger, more attainable financial future from a health event they never expected to financially ruin them.

With limited options on covering healthcare debt, many individuals choose to avoid healthcare all together in fear of not being able to afford the care they need. Those that could be impacted most within the public health sector by a healthcare debt CDFI program would be individuals, healthcare institutions and the economy.

Public health is significant in this policy because individuals would be given an opportunity to take control of their financial situation and not feel overburdened by their financial inability to access healthcare. Those that found themselves in medical debt were more likely to forego needed medical treatment and medications (Himmelstein, et al., 2019). Individuals should not have to choose rather or not they are going to seek or undergo treatment based on their financial situation. Having access to a CDFI program that gives them more financial peace of mind could support individuals and their active participation in public health.

Healthcare institutions are also part of the larger public health system, in providing health screenings and treatment to individuals to live a more productive life and providing health advice. Most healthcare institutions focus on their patient's and providing the best quality care possible and then try to get reimbursed for the services rendered after the treatment has taken place.

However, to pay their staff, cover the cost of care and overhead, healthcare institutions must be paid for the services they provide to continue to provide the services within the community they serve. The healthcare debt CDFI program would send the approved loan funds for an individual directly to the hospital for the amount the individual has been approved for up to the cost of the existing bill. While the bill may not be covered in full, it would be less of a burden on the healthcare institution than not receiving payment and/or having to sue the patient for non-payment.

The more individuals that have to declare bankruptcy each year, the higher the burden on the overall US economy. Reducing the number of bankruptcy cases per year on account of healthcare debt could provide a more stable economy in the long-term. With over half of US citizens filing bankruptcy from 2013 to 2016 attributing medical expenses as a major factor, it is important for the US to take notice and find policy solutions to this significant public health issue (Himmelstein et al., 2019, p. 432).

4.1 Recommendations

Additional potential policies that should be considered based on the research presented in this paper include a policy that would ban insurance companies from providing “junk” healthcare plans; therefore, reducing the number of underinsured individuals (Abutaleb, 2019). These plans would have to cover up to at least 70 percent or higher of an individual’s coinsurance and the deductible would have to be less than four percent of an individual’s annual income. This particular policy would be controversial and be less likely to pass through Congress. However, it would be a strong recommendation within the current surprise billing legislation being debated in Congress.

5.0 Conclusion

Healthcare debt in the US is a significant, billion-dollar issue that has many economists, administrators and policy makers baffled. If there was an easy answer, there would already be a solution. While healthcare debt may never be eliminated, solutions such as the ones provided in this paper would reduce the economic pinch on healthcare consumers and institutions and decrease the number of bankruptcies in the US that are attributed to healthcare debt. There is still much to be considered and researched to provide the additional needed policy issues at the federal, state, local and employer levels. However, providing a sensible, attainable lending option to the millions of individuals that find themselves in hard hit financial situations from healthcare debt, the US can reduce the economic strain on individuals and healthcare institutions over time.

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